Government of the District of Columbia
Office of the Chief Financial Officer

Natwar M. Gandhi
Chief Financial Officer

MEMORANDUM

TO: **The Honorable Philip H. Mendelson**
Chairman, Council of the District of Columbia

FROM: **Natwar M. Gandhi**
Chief Financial Officer

DATE: **October 4, 2012**

SUBJECT: **Fiscal Impact Statement – "Medicaid Fraud Enforcement and Recovery Amendment Act of 2012"**

REFERENCE: **Bill 19-224, Draft Committee Print shared with the Office of Revenue Analysis on September 11, 2012**

Conclusion

Funds are sufficient in the FY 2013 through FY 2016 budget and financial plan to implement the bill.

Background

Medicaid is a joint funded program between states and the Federal Government, so when false claims are prosecuted, the settlements and judgments are also shared between the jurisdictions. The District passed its first false claims laws to combat Medicaid fraud in 1986;[1] at the time the District's false claims laws loosely followed the Federal False Claims Act (FFCA),[2] which had been substantially amended the same year.[3] Since then, the FFCA has been modified a number of times,[4] notably to include a financial incentive for states that amend their false claims acts[5] to meet the expectations of the federal program.[6] If changes to the District's false claims laws are enacted, this

[1] The District of Columbia Procurement Practices Act of 1985, effective February 21, 1986 (D.C. Law 6-85; D.C. Official Code § 2-301.01 *et seq.*).
[2] 31 U.S.C. §§ 3729-3733.
[3] False Claims Amendments Act, enacted October 27, 1986 (Pub.L. 99-562; 100 Stat. 3153).
[4] Most significant changes were made in 2009, with the enactment of the Fraud Enforcement and Recovery Act of 2009 (Pub.L. 111-21;123 Stat. 1617) and then in 2010, with the Patient Protection and Affordable Care Act (Pub.L. 111-148; 124 Stat. 119)
[5] First authorized in the Deficit Reduction Act of 2005, effective February 8, 2006 (Pub. L. 109-171; 120 Stat. 4).
[6] As of the bill's proposal date, only 14 states qualify for the financial incentive.

incentive would result in the District receiving an increased payout from 30 percent to 40 percent from Medicaid fraud settlements and judgments. Additional changes to the FFCA included increases in the ability to share information among jurisdictions, changes to public disclosure requirements, protections against retaliation for *qui tam* plaintiffs,[7] to name a few.

The main purpose of the bill is to amend the District's false claims laws so the District would qualify for the increased financial compensation associated with settlements and judgments. Many of the bill's other changes are technical in nature, but some involve changes to the *qui tam* plaintiff's rights. These include restrictions on the number of witnesses a *qui tam* can call and the length of each witness' testimony, or the *qui tam* plaintiff's ability to cross-examine witnesses if those actions will interfere with the District's ability to prosecute a case. The bill increases the minimum award amount to a *qui tam* plaintiff from 10 percent to 15 percent of the settlement amount of the case if the District participates in the case. If the District elects not to participate, the maximum award for a *qui tam* is reduced from 40 percent to 30 percent. Other changes to *qui tam* rights include the extension of those rights to non-court remedies the District may pursue, including administrative hearings, ensuring no awards are made if the *qui tam* is convicted of criminal conduct as a result of the his or her role in the violation, and allowing the District to petition the courts to put a stay on *qui tam* proceedings if it would interfere with the investigation or prosecution of a criminal or civil matter by the District.

Lastly, the bill increases the civil penalty range from $5,000 to $10,000 per fraudulent claim to $5,500 to $11,000 per claim.

Financial Plan Impact

Funds are sufficient in the FY 2013 through FY 2016 budget and financial plan to implement the bill. The changes proposed in the bill were preliminarily approved by the Office of the Inspector General at the United States Department of Health and Human Services. This approval is required to receive the increased reward of 40 percent from settlements and judgments. All proceeds are deposited in the Medicaid Collections–Third Party Liabilities Fund, a special purpose fund that supports the District's Medicaid program. Because it increases the District's share in payouts from 30 to 40 percent, enactment of the bill will increase revenues for the Fund, but given the uncertainties regarding the timing of judgments, and the receipt of recoveries, it is not possible to project a specific amount.

That said, the impact on the Fund could be substantial. For example, recoveries for the last five fiscal years have averaged nearly $1.5 million per year with a high of $4.4 million in fiscal year 2009 and a low of $314,947 in fiscal year 2011. If the District had enacted these reforms and qualified for the additional recovery, the average annual recovery would have been 33.3% higher or nearly $2 million.

[7] *Qui tam* actions are those brought by private citizens who have intimate knowledge that fraudulent activities have taken place. These citizens become party to the action in court and could be joined by a state or federal entity. Whether or not the state becomes party to the action will dictate the *qui tam* plaintiff's claim to settlements and judgments resulting for the action.